Expanded and Improved Medicare for All: Beware of Greeks Bearing Broccoli

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By Marilyn M. Singleton

During the Supreme Court oral arguments in the challenge to the Affordable Care Act's mandate to purchase health insurance, people laughed when the late Justice Scalia asked whether the government could make you buy broccoli. Never happen? The laughable has become reality. A California bill awaiting the governor's signature forbids restaurants from serving any beverage other than water or unflavored milk with kiddie meals. As of yet, the meal's purchasers, unlike the restaurant, won't be fined for ordering another beverage for their child.

Shrugging off assertions that the ACA was about control, not care, President Obama quipped that his opponents acted like the ACA "was a Bolshevik plot." That supposedly ludicrous plot is embodied in a too-good-to-be-true congressional bill, H.R. 676, the "Expanded & Improved Medicare For All". Vote-seeking congresspersons have breathed new life into this 2003 creation. With no dollar amounts in sight, the bill gives the government a blank check to exert total control over our medical care.

H.R. 676 provides that all individuals residing in the United States showing up at the doctor's office are "presumed to be eligible" for benefits. The federal government will pay for unlimited "medically necessary" health expenses, including pharmaceuticals, mental health, substance abuse, vision, dental, hearing, and long-term care — with no deductibles or other cost-sharing. Unless a patient opts out, all interactions will be memorialized in a "standardized, confidential electronic patient record system." Yes, those same electronic records that have been hacked and are contributing to physician burnout.

Overseen by regional offices and the Presidentially appointed 15-member National Board of Universal Quality and Access, participating institutions will receive separate monthly fixed sums for capital expenses (e.g., buildings, improvements) and for operating expenses (including physician salaries). Non-salaried physicians can be paid based on a national fee schedule that is "fair and optimal" as decided by the government. Finally, each geographic region would receive a single allotment to cover long-term care.

There are some restrictions. Only public or not-for profit institutions may participate. Private physicians and clinics can exist but cannot be investor-owned. And to keep the patients on the reservation, private health insurers are prohibited from selling health insurance coverage that duplicates the government-sponsored benefits.

Ever magnanimous, the government will pay for "reasonable financial losses" resulting from the conversion from for-profit to nonprofit status through the sale of U.S. Treasury bonds, assuming we choose to buy them. Additionally, the government will compensate insurance and other relevant clerical, administrative, and billing personnel up to $200,000 per person for losing their jobs.

Patients would have "free choice of participating physicians and other clinicians, hospitals, and inpatient care facilities." But under the business restrictions and capped payments, the better institutions and clinicians may choose not to participate, thus decreasing access.

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There is a big bad wolf in this fairy tale. In 2016, the feds spent more than $1.2 trillion on Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Total national health expenditures by all government levels and private entities were $3.3 trillion.

H.R. 676 provides funding from appropriations for federal public health care programs, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP); an unspecified increase on personal income taxes on the top 5 percent of income earners; a “modest and progressive” excise tax on payroll and self-employment income; a “modest” tax on unearned income, and a “small” tax on stock and bond transactions.

Fast forward to 2026, when the government predicts that the Medicare Hospital Insurance Trust fund will be depleted and total national health expenditures will be $5.7 trillion. The federal government collected about $100 billion in Medicare premiums and a total of $3.32 trillion in taxes last year. Given the projected costs, no cost-sharing, and the $2.4 trillion shortfall, the bill’s “modest” tax increases will soon be obscene.

Not only will the benefits decrease as the money runs out, patients will see real world consequences of total control. For example, Oregon’s Medicaid program wants to limit coverage for opiates for some chronic pain conditions and taper off patients who have been taking opioids long-term — even if they have no signs of addiction. Long-term care will be an easy target; the ACA’s long-term care program was scuttled due to cost concerns. With current nursing home costs averaging $7,500 per month, inevitably when the monthly allotment is depleted, hospice care becomes the medically necessary treatment.

Tell the sponsors of H.R. 676 that it’s your money, your health, your privacy, your life. The government is neither our parent nor our benefactor. The government is not the middleman you want between you and your doctor. At a time when the movement toward innovative and personalized care is moving forward, care via government control is taking us backwards.